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I Was Drugged Before I Was Diagnosed: A Forensic Account of Psychiatric Misconduct at North Bay Regional Health Center.

"Are you going to continue experimenting on me?" — Dr. Vivien Mary Parker quoting patient (CPSO #68883), April 9, 2025 (pg. 103, NBRHC records). A legal exhibit documenting sedation, deception, and rewritten identity at North Bay Regional Health Centre.

Lxfx 39 min read · May 24, 2025

Submitted as Exhibit to CPSO (June 3, 2025) and HRTO (July 27, 2025) — Part of Active Complaints:
HRTO File #: 2025–61450-I • CPSO Complaint #: CAS-485715-F3T5Z0

This is not a story of psychiatric or legal complexity — it is a record of legal violations hiding behind medical authority. What happened to me at North Bay Regional Health Centre does not require a diagnosis to understand. It requires only a timeline, a set of signed forms, and a willingness to see that sedation, solitary confinement, and forced medication were administered before any legal basis existed — and that the people responsible recorded it all themselves.

🗒️ Why This Case Requires No Legal or Medical Nuance

This is not a story of psychiatric or legal complexity.

No trauma appeal is required.
No professional interpretation is needed.
This is a matter of documented **law and misconduct**.

The hospital's own records prove:

- Sedation before any legal process
- Capacity deemed absent, without required forms
- Chemical restraint used to silence consent
- False statements submitted in sworn documents

The question is not what someone *believes*.
It is whether we will uphold the **law.**

This is not an opinion piece — it is a forensic exhibit. The events described here took place during a 21-day involuntary admission at *North Bay Regional Health Centre (NBRHC)* in March and April of 2025. The following documentation outlines a case of chemical sedation prior to psychiatric diagnosis, the suppression of disclosed trauma, and a sustained effort by hospital staff and physicians to pathologize trauma responses instead of investigating them. Every detail is supported by hospital records, tribunal documents, and physician notes — all of which have been submitted to the College of Physicians and Surgeons of Ontario (CPSO) and the Human Rights Tribunal of Ontario (HRTO). This is the public record.

These are the documented facts. Any official decisions from oversight bodies will be publicly recorded alongside this article. Their rationale — or lack thereof — will be included for transparency.

📌 Posting

- “Personal Record — Factual Summary of Psychiatric Detainment”

This is **in good faith**, **for public accountability**, and **to ensure this never happens to others. This is for my own safety.**

“All statements are based on verifiable documentation and hospital records. I welcome lawful review and deny any intent to defame.”

✍️ Mission Statement (for Medium, HRTO, CPSO, or Public Use)

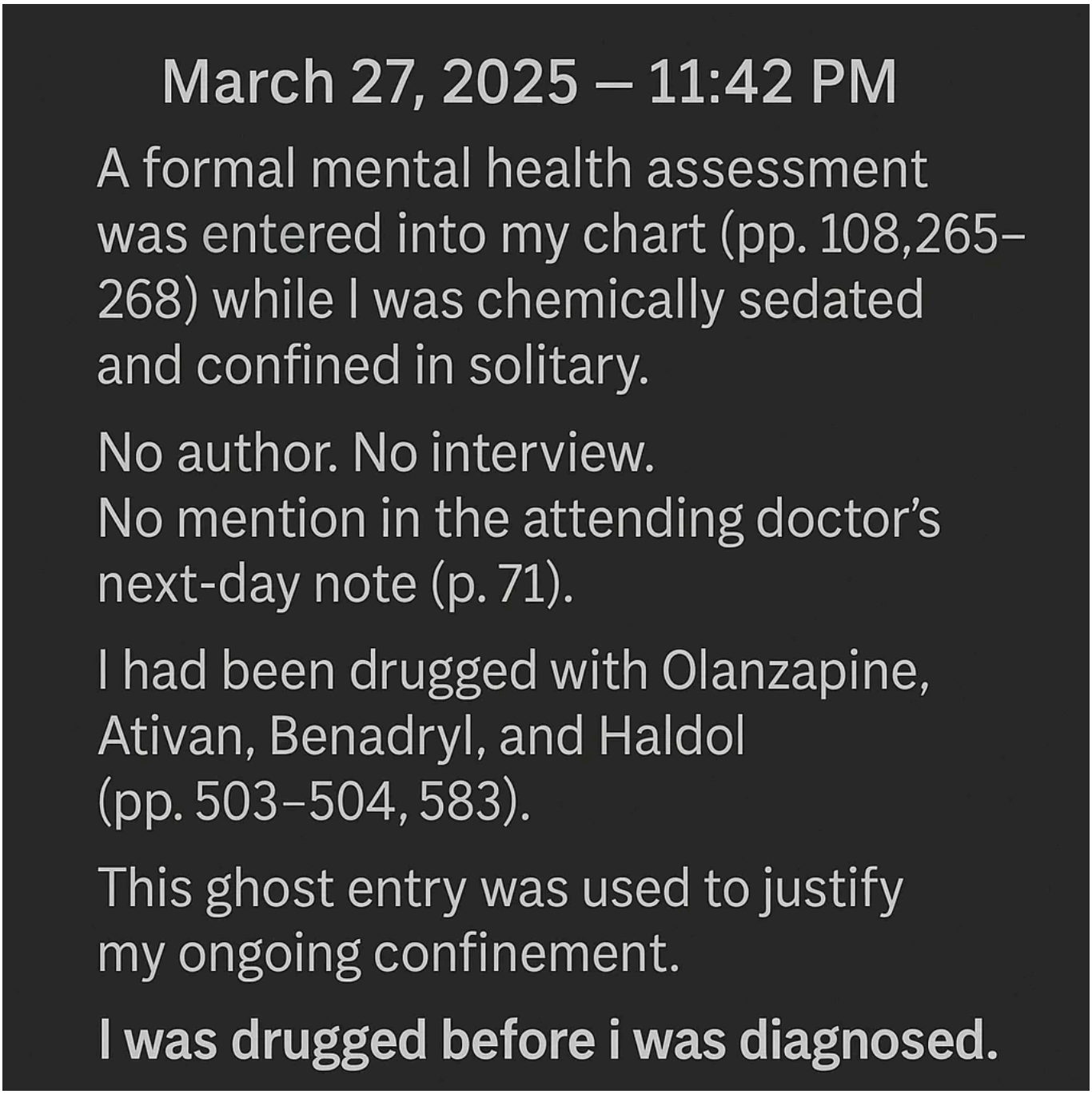
Master Case Summary: Involuntary Confinement and Procedural Violations at North Bay Regional Health Centre

Legal Matrix of Violations / Form 50 signed March 27 11:30 am and form 33 March 27 8:40am following prolonged sedation and seclusion

Civil Litigation Readiness Statement

🔎 **Dr. Vivien Mary Parker’s Form 2 HRTO Response: Omissions and Contradictions** *(Form 2 filed July 3, 2025. Received July 17, 2025.)* (CPSO#: **68883**)

“This article reflects the author’s understanding based on official hospital documents and tribunal filings. It is open to correction should new verified information arise.”

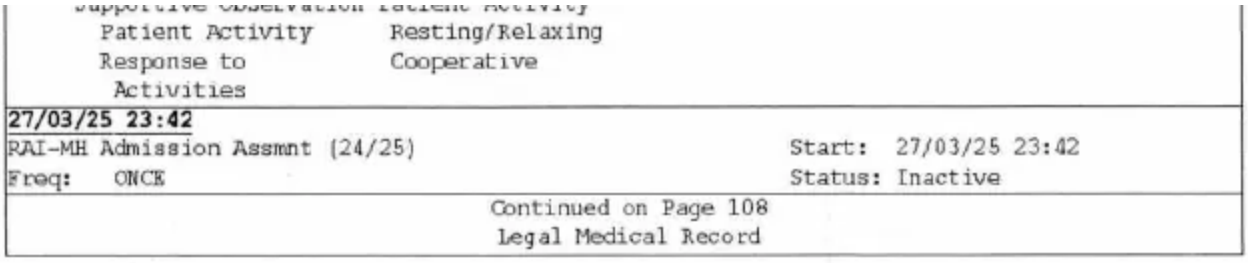

March 27, 2025 – 11:42 PM
A formal mental health assessment was entered into my chart (pp. 108,265–268) while I was chemically sedated and confined in solitary.
No author. No interview.
No mention in the attending doctor's next-day note (p. 71).
I had been drugged with Olanzapine, Ativan, Benadryl, and Haldol (pp. 503–504, 583).
This ghost entry was used to justify my ongoing confinement.
I was drugged before i was diagnosed.

MHA assessment dated March 27 at 11:43 p.m. was a copy-paste of the March 24 emergency intake assessment (see pages 11–13 of file).

Why was this done?

The RAI-MH assessment — the required psychiatric tool for admission under Ontario law — was not even **attempted** until 11:42 p.m. on March 27, nearly

four full days after admission, and **remained incomplete.** This not only invalidates earlier forms issued under the Mental Health Act (Form 1, 3, 33, 50), but also confirms the patient was chemically sedated and secluded *without* the necessary psychiatric evaluations, rendering the process unlawful and procedurally incoherent.



Patient Activity	Resting/Relaxing
Response to Activities	Cooperative
27/03/25 23:42	
RAI-MH Admission Assmnt (24/25)	Start: 27/03/25 23:42
Freq: ONCE	Status: Inactive

Continued on Page 108
Legal Medical Record

No valid formal MHA ever occurred only an ED assessment. No emergency declared. Patient sedated and issued resuscitation orders on admission. No acts of violence, threat, criminal record, consent, SDM, or HCCA Form 5 recorded on admission. Form 50 and 33 signed under chemical sedation March 27, 11:30am after requesting rights repeatedly. p.82 March 27 Dr.Parker's narrative notes.

This article documents my experience and legal complaint under the **Ontario Human Rights Code**, currently under review by the **Human Rights Tribunal of Ontario (HRTO)** and the **College of Physicians and Surgeons of Ontario (CPSO).** All names and records are drawn from official documentation received or filed as part of these proceedings.

🔗 Legal Timeline and Procedural Violations During involuntary Hospitalization

❌ **"Patient was not chemically sedated again after March 24, 2025." — Dr. Vivien Mary Parker, HRTO Form 2 Response**

of the Applicant's care while admitted to the Acute In-Patient Psychiatry unit was to stabilize him and keep him safe, which required urgent aggressive treatment; the level of acute psychosis he was exhibiting was not expected to resolve without treatment. Despite this, the Applicant was not chemically sedated again after March 24, 2025.

Dr. Parker's signed Form 2 response (dated July 3, 2025), Schedule A, page 3, paragraph 10

This quote appears in Dr. Parker's signed Form 2 response (dated July 3, 2025), *Schedule A, page 3, paragraph 10*, and is directly contradicted by both her own clinical notes and the official hospital medication records.

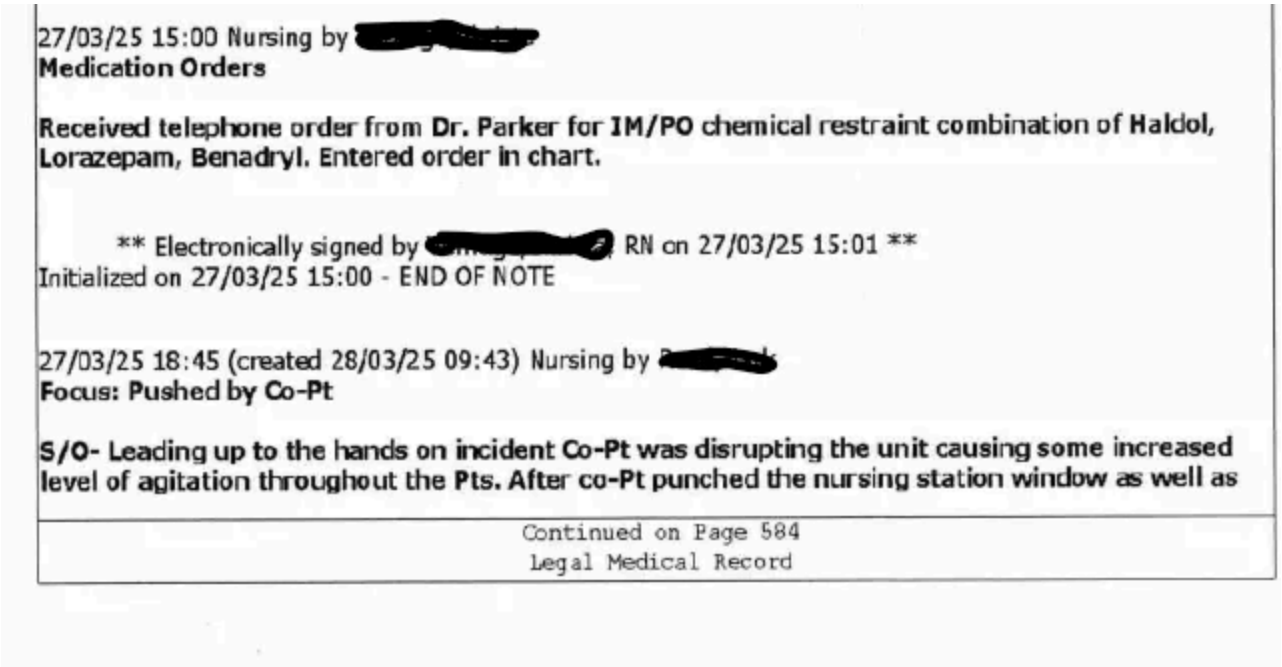
I completed a form 33 this morning which was the earliest opportunity having waited to secure a substitute decision maker prior to completing this form.

I went to see Lee who is now in the seclusion room. He had had a terrible night and received chemical restraint at 1601 hrs. on 26 March 2025. At that time he was agitated and angry, lifted his leg and threatened to kick staff. A code White was initiated and he received Haldol, Ativan and Benadryl and was placed in the seclusion room

Dr, Parkers March 27 Narrative directly contradicting her Form 2 response p. 81. Patient chemically sedated and confined after trying to console a fellow patient on March 26, 2025. No violence or threat occurred. A narrative begins to build on expressed trauma, repeated chemical sedation and seclusion. Form 50 and 33 singed while sedated.

Dr. Parker's signed clinical note (March 27, page 81):

"He had a terrible night and received chemical restraint at 1601 hrs on 26 March 2025… He received Haldol, Ativan and Benadryl and was placed in the seclusion room."



27/03/25 15:00 Nursing by [redacted]
Medication Orders

Received telephone order from Dr. Parker for IM/PO chemical restraint combination of Haldol, Lorazepam, Benadryl. Entered order in chart.

** Electronically signed by [redacted] RN on 27/03/25 15:01 **
Initialized on 27/03/25 15:00 - END OF NOTE

27/03/25 18:45 (created 28/03/25 09:43) Nursing by [redacted]
Focus: Pushed by Co-Pt

S/O- Leading up to the hands on incident Co-Pt was disrupting the unit causing some increased level of agitation throughout the Pts. After co-Pt punched the nursing station window as well as

Continued on Page 584
Legal Medical Record

Hospital Records p. 503 Chemical coercion continues

Why would Dr. Parker's statement to the HRTO be contradictory? Stating the Applicant was not chemically sedated again after March 24, 2025, when her own clinical notes and hospital records record otherwise?

📍 Form 33 and 50 sequence

Summary of Contradictions and Omissions in Dr. Parker's HRTO Form 2 Response Here.

✅ **Hospital medication records** (pages 503–504, 583, and 641–680) confirm continued administration of **Olanzapine, Ativan, Haldol, Diphenhydramine, Dayvigo**, and more — often with fallback IM injection protocols — well past March 24 and up to April 14, 2025, the date of tribunal-ordered discharge.

🚨 This contradiction indicates that **Dr. Parker appears to have misrepresented critical facts in an official HRTO response.** These documents — including the full medication chart — were publicly available

and shared with regulators as part of a professional accountability process. Respondents were expected to consult this documentation before submitting sworn responses.

🧩 Notably, **the hospital's own Form 2 HRTO response does not repeat this false claim.** This critical distinction places Dr. Parker alone in asserting that no chemical sedation occurred after March 24, 2025 — a statement proven false by both her clinical notes and the hospital's medication logs. By misrepresenting the record to a Human Rights Tribunal, Dr. Parker attempted to validate a sequence of involuntary forms and justify bypassing consent — relying on the Consent and Capacity Board as a shield.

This now places the HRTO, CPSO, and institutional respondents in a position where *continuing to rely on that shield implies endorsement of misrepresentation.* Whether intentional or negligent, this falsehood undermines the integrity of the tribunal process and demands review.

Throughout my hospitalization, I was never violent or aggressive — even after being assaulted by another patient. I repeatedly asked to be left alone. This request was rooted in a justified loss of trust after **intake physician Dr. Murray Meek** (CPSO#: **79444**) **misrepresented his identity** — a fact confirmed in his own notes. My reasonable suspicion and refusal to comply were later pathologized as paranoia.

He has no other past medical history no medications

Examination vitals 154/104 remainder vitals normal. Eye contact was good thoughts were incoherent speech was pressured and he started asking me about the Arctic and finding certain people out there from the safety program. I played along with it for a while but eventually he asked me specific details which I could not answer. For example he asked me about the 5 point safety plan.

March 24, 2025 Intake assessment. Dr Meek impersonates a former colleague similar in appearance. This is understood by the patient and shatters trust later pathologized as paranoia p.70

March 24, 2025 — Intake Deception and Breach of Trust

- During intake, **Dr. Meek impersonates a former mining colleague**, closely resembling someone the patient had previously worked with.
- This impersonation is recognized by the patient, who initially trusts him due to the familiarity.
- Upon realizing the deception, the patient experiences a profound **loss of trust**, which later becomes a turning point in their reluctance to engage.
- This reaction is **subsequently pathologized as paranoia** in clinical notes.
- **Source: p. 70** — confirms Dr. Meek admitted to "playing along."
- No emergency was declared, and no valid Substitute Decision-Maker (SDM) or Form 5 under the Health Care Consent Act (HCCA) existed prior to the administration of medication. This means every dose given from the point of hospital entry was unlawful under HCCA. A resuscitation order was also issued based on outdated bloodwork taken over six months earlier. The Form 1 was signed one day after admission, on March 25, 2025, using an incorrect address and a fabricated narrative that contradicts clinical records and witness accounts.

The medications I was administered — including sedation, **chemical restraints** — and the **resuscitation order** that followed, were not consented to. This non-consensual intervention became the foundation of Dr. Parker's assessment and narrative, which omitted critical context and misrepresented my condition from the outset. The forced medication, resuscitation order, sleep deprivation, and dehydration were not noted in Dr. Parker's March 25, 2025 narrative the following day.

A psychiatric detainment story from Northern Ontario.
Where trauma was misread, law was bypassed, and dignity was erased.

This is the documented public record.

Keywords: psychiatric abuse, forced medication, Ontario healthcare, trauma-informed care, human rights

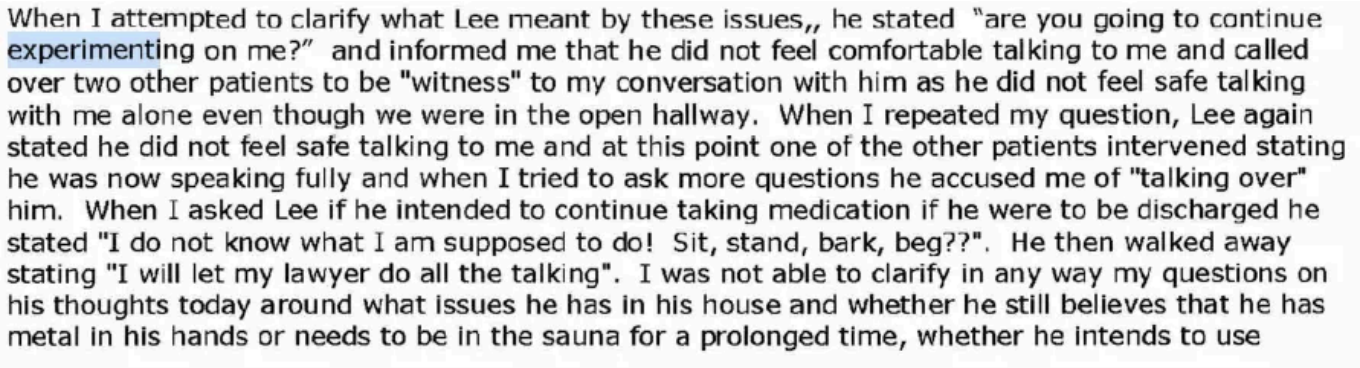
Updated July 12, 2025

> "Linked here is a full legal violations matrix prepared for the HRTO and CPSO. All allegations are backed by hospital records, physician forms, tribunal documentation, and internal memos. This is a factual matrix, not an emotional plea — and it is shared for the public record in pursuit of transparency and accountability."

Correction Notice (Updated):
This article has been revised to correct earlier misstatements, including a previous belief that no Form 5 existed. Upon further review, a **Form 5 under the Mental Health Act (MHA)** — *Change to Informal or Voluntary Status* — was located and is now fully integrated into the public timeline.

However, the **capacity-related documentation required under the Health Care Consent Act (HCCA)** — often informally referred to as a "Form 5" — is **still absent** from my medical record. This document is required by law before initiating forced treatment or appointing a substitute decision-maker.

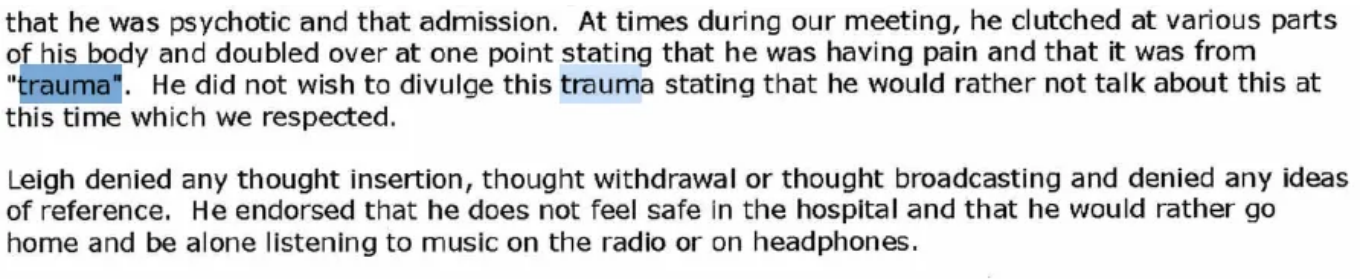
While the MHA Form 5 exists, its **timing and usage — filed only after a tribunal-ordered release — reinforces** the core concern: that my discharge was not the result of clinical discretion, but legal intervention. The HCCA violation remains legally and ethically unresolved.



When I attempted to clarify what Lee meant by these issues,, he stated "are you going to continue experimenting on me?" and informed me that he did not feel comfortable talking to me and called over two other patients to be "witness" to my conversation with him as he did not feel safe talking with me alone even though we were in the open hallway. When I repeated my question, Lee again stated he did not feel safe talking to me and at this point one of the other patients intervened stating he was now speaking fully and when I tried to ask more questions he accused me of "talking over" him. When I asked Lee if he intended to continue taking medication if he were to be discharged he stated "I do not know what I am supposed to do! Sit, stand, bark, beg??". He then walked away stating "I will let my lawyer do all the talking". I was not able to clarify in any way my questions on his thoughts today around what issues he has in his house and whether he still believes that he has metal in his hands or needs to be in the sauna for a prolonged time, whether he intends to use

Dr. Parker Narrative April 9 2025 p.103

There are still visible metal fragments embedded in the palms of my hands — the result of years of mechanical work. Rather than recognizing this as a physical consequence of my trade, it was pathologized. All the doctor had to do was look.



that he was psychotic and that admission. At times during our meeting, he clutched at various parts of his body and doubled over at one point stating that he was having pain and that it was from "trauma". He did not wish to divulge this trauma stating that he would rather not talk about this at this time which we respected.

Leigh denied any thought insertion, thought withdrawal or thought broadcasting and denied any ideas of reference. He endorsed that he does not feel safe in the hospital and that he would rather go home and be alone listening to music on the radio or on headphones.

Dr. Parker Narrative March 25 2025 p. 76 first meeting

Hospital records falsely indicate that no trauma history exists. Despite direct disclosures to both Dr. Parker and nursing staff — including experiences of assault, trafficking exposure, and workplace-related trauma — Dr. Parker's narrative never acknowledges trauma as a psychological driver. Instead, she omits or pathologizes these disclosures, constructing a diagnosis without context.

Why I'm Telling This Story

This is not a story I ever wanted to tell — and certainly not one I expected to publish under my own name.

Between March 24 and April 14, 2025, I was involuntarily detained at North Bay Regional Health Centre. During that time, I was forcibly medicated, denied the right to make decisions about my own treatment, and repeatedly misrepresented in my medical record.

Everything I describe in this article is backed by dated, time-stamped hospital documentation. Any claim I make can be referenced by exact page numbers in the medical records I've reviewed — over 700 pages in total uploaded to a cloud May 20, 2025.

I'm not telling this story out of anger or revenge. I'm telling it because I believe what happened to me is not unique — and because others caught in the same system may not have the tools, support, or opportunity to speak up.

I also believe it's important that this story be public — not just for advocacy, but for my own safety.
When institutions rewrite your history on paper, the best protection you have is a record they can't control.

So, if this is long — or hard to read — I apologize. But the detail matters. Because what happened to me wasn't just one mistake, it was a series of decisions that only make sense if no one was ever supposed to look too closely.

It's not a story I wanted, but it's mine.

Who I Am

A father and a family man. Before this happened, I was working in remote mining jobs and doing memory recovery to process years of trauma from childhood and my time bartending in violent, drug-exposed environments.

I had recently been placed on sick leave after passing out on the job and was receiving unemployment while looking for safer, more suitable work. I was not unstable — I was exhausted from a lifetime of pushing through trauma and finally trying to rest and recover.

I was taking time to heal.

For over eight months, I had been actively working on **rebuilding my body, nervous system, and mind**. I used sauna, cold exposure, and deliberate rest to heal from physical injury and stress. I was studying trauma and its effects on the body, learning to recognize and release the tension I had carried for years.

I also used tools like ChatGPT and Google Maps to build what I called an **external neural network** of memories — pinning physical locations to events in my life and working through them one by one. It was the most organized and focused effort I had ever made to recover from the trauma I had spent years suppressing.

I documented everything — including the descent into psychosis and my recovery out. I still have those records. They are timestamped, and I retain memory of most of it.

But my efforts were **dismissed and ridiculed.** A doctor later described this as "an affair with AI," ignoring both the intention and the results. They insisted I had experienced a marijuana-induced psychosis — even though **hospital intake records clearly state I was not intoxicated** and showed no signs of alcohol or marijuana use. The diagnosis was baseless.

After eight days without sleep, I entered what I now understand to be a **trauma-induced psychotic state** — what I can only describe as "dreaming while awake."

In that state, I began seeing the faces of people I had witnessed suffer — at the mine, behind the bar, in the communities I had tried to protect. I was physically and emotionally worn down, but still clear-minded enough to ask for space, to speak calmly, and to try to avoid harm.

When I arrived at the hospital, what I needed was **trauma-informed care**.

Instead, I was treated like a threat, chemically restrained without consent, and declared incapable without legal process.

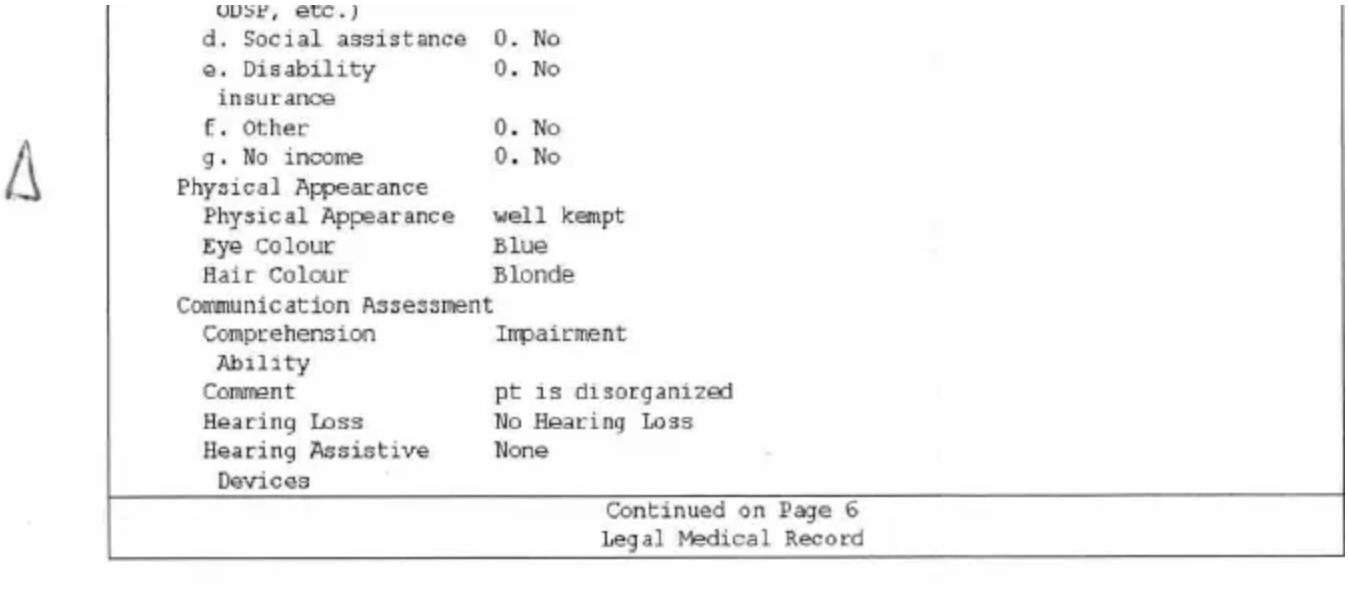
My trauma was ignored, my words twisted, and my story nearly buried — until now.

What Happened to Me

Intake Errors That Set the Tone

Before any assessment or medication was administered, my hospital records were already filled with basic errors. These included but are not limited to:

- Listing my hair and eye color incorrectly (“blonde hair, blue eyes”) when I have brown hair and brown eyes



ODSP, etc.)	
d. Social assistance	0. No
e. Disability insurance	0. No
f. Other	0. No
g. No income	0. No
Physical Appearance	
Physical Appearance	well kempt
Eye Colour	Blue
Hair Colour	Blonde
Communication Assessment	
Comprehension Ability	Impairment
Comment	pt is disorganized
Hearing Loss	No Hearing Loss
Hearing Assistive Devices	None

Continued on Page 6
Legal Medical Record

- Contradicting themselves by describing me as both “well kept” and later “unkempt” or “disorganized”
- Stating that I had “no income” and unemployed, when I was on medical leave from a mining job and receiving unemployment
- Leaving my educational background as high school educated, despite my university education and licensed red seal mechanic.

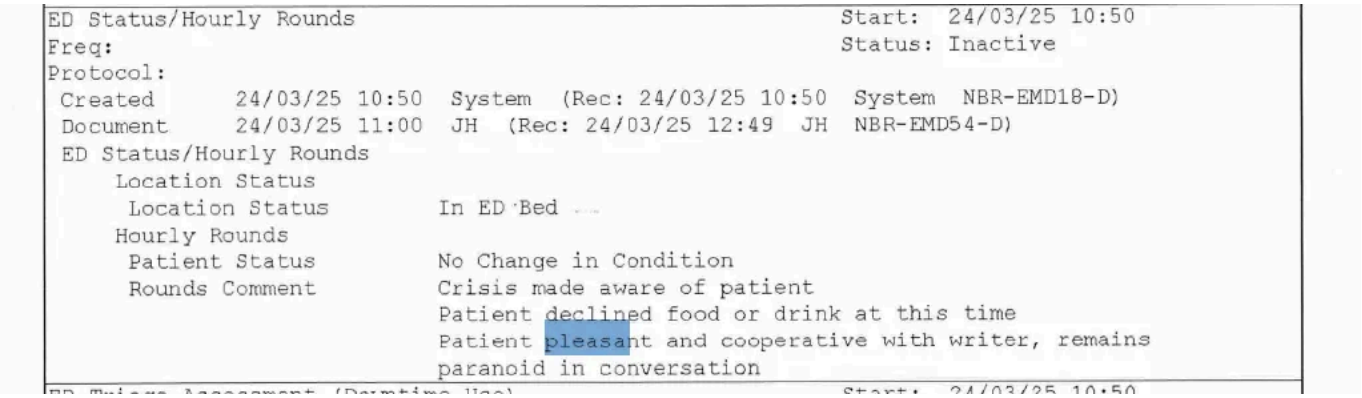
additional codes.	
5. EDUCATION	
Protocol: .MBB5.21	
Education	4. High school
6. SOURCES OF INCOME	
Protocol: .MBB6.21	
a. Employment	0. No
b. Employment	1. Yes

These are not small details. They show a pattern: the intake process was careless, presumptive, and devoid of the most basic fact-checking.
That tone — of not listening, not seeing, and not caring — continued through every part of my hospitalization. In total, I have documented well over 100 factual errors and discrepancies across intake records, physician narratives, diagnostic claims, and discharge documentation — each supported by timestamped evidence.

March 24, 2025 — I Arrived Calm but Was Drugged Before Any Psychiatric Evaluation

I was brought to the hospital from my home during a wellness check — not due to any emergency, violence, or criminal concern. I have no criminal record. I was physically and mentally exhausted after approximately **eight days without sleep**, but I remained **coherent, cooperative, and calm**, as described in the nursing notes.

> Nurses documented that I was **"pleasant and cooperative"** with **no signs of violence or aggression.**
> My Glasgow Coma Scale (GCS) score was **14/15**, indicating **medical stability** on arrival.

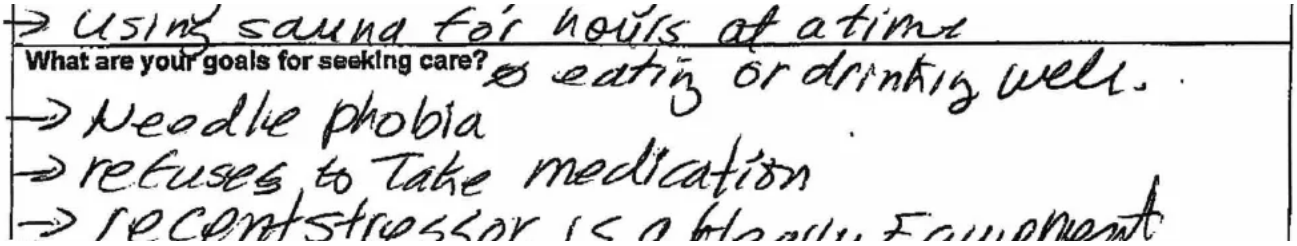


ED Status/Hourly Rounds — Start: 24/03/25 10:50
Freq: — Status: Inactive
Protocol:
Created 24/03/25 10:50 System (Rec: 24/03/25 10:50 System NBR-EMD18-D)
Document 24/03/25 11:00 JH (Rec: 24/03/25 12:49 JH NBR-EMD54-D)
ED Status/Hourly Rounds
Location Status
Location Status: In ED Bed
Hourly Rounds
Patient Status: No Change in Condition
Rounds Comment: Crisis made aware of patient
Patient declined food or drink at this time
Patient pleasant and cooperative with writer, remains paranoid in conversation

Labeled Paranoid desptite Dr. Meeks “played along p 70” misrepresenting person and being caught.

Despite this, I was **forcibly drugged before any psychiatric assessment took place**: No Form 5 HCCA signed for missing SDM, No Form 33 signed until March 27 under sedation.

- At **12:50 p.m.**, I was administered **Olanzapine and Ativan** without consent or legal certification.
- At **3:00 p.m.**, I was injected with **Ceftriaxone**, a powerful intravenous antibiotic, despite being **clinically dehydrated** and without any current infection (the antibiotic was ordered based on **outdated labs**).
- At **15:32**, staff entered a “**Full Resuscitation**” **order**, suggesting they knew the medical risks involved in administering this drug cocktail under my fragile condition. They did not accpet the documented needle phobia and proceeded based on blood work given 8 months prior. This is I began to black out and locked myself in the washroom in the ward. Then I was chemically restrained. The following day Dr. Parker began her narrative and made no mention of this sequence of events or forced medication without concent.


→ using sauna for hours at a time
What are your goals for seeking care? ∅ eating or drinking well.
→ Needle phobia
→ refuses to take medication

Documented needle phobia page 624

> No psychiatric certification (Form 1) had been issued at the time of these druggings. No form 33 had been signed, No HCCA form 5 or SDM appointed. When Form 1 was eventually signed by Dr. Meek on **March 25**, it included **false information** (a fabricated narrative), an **incorrect home address**, and was signed **after the fact**, while I was already under chemical sedation. **Dr. Meek later admitted to "playing along" with my supposed delusions before breaking character and filing paperwork retroactively.**

At the time, **my vision was blurred.** I could not clearly see Dr. Meek, but told him he resembled someone I remembered from my time in the Arctic. When I asked him to read aloud the paperwork he was citing — because I could not read it myself — **he refused.** I was left unable to meaningfully understand or respond to what was being imposed on me.

I experienced **hallucinations, memory blackouts, dissociation, and extreme disorientation** following the forced injection and drugs — before I was ever assessed under the Mental Health Act or told my legal rights.

These actions occurred **in the absence of any Substitute Decision Maker (SDM)**, legal certification, or behavioral justification. They are now documented as **unauthorized forced medical interventions** carried out **in violation of my Charter rights** and Ontario health law.

🛑 *Contrary to what may be implied, the ED mental health intake dated March 24–25 was not a valid Mental Health Act or Health Care Consent Act assessment. No Form 33 was issued upon arrival, no capacity assessment (colloquially 'Form 5 HCCA') was performed, and the errors in this intake (e.g., "high school education," "spoke marijuana as much as I can") were later duplicated in a fabricated March 27 MHA record under sedation.*

🚨 *Hospital staff may claim emergency authority to medicate, yet no such documentation exists. There was no Form 1 at the time, no recorded violent behavior, and no emergency finding of incapacity — only a "comfort measure" administered after I asked to be left alone. The emergency exception cannot be applied retroactively, and its misuse here voids legal and ethical justifications for forced sedation.*

🔎 The 12 Questions That Collapse the Case

March 24–26 — Capacity Ignored, Trauma Misread

- **Form 1** was signed **one day after admission** (March 25), yet I had already been administered sedating and antipsychotic medications **without any psychiatric evaluation or legal justification.**
- These drugs were administered **prior to any behavioral incident**, and immediately followed a **"Full Resuscitation"** order.

Medications were administered on March 24 before any psychiatric evaluation under the Mental Health Act (MHA) — only a brief and error-filled Emergency Department (ED) assessment was conducted earlier that

day, which lacked any formal capacity review or mental status examination required under Ontario law.

- Olanzapine ODT (Zyprexa Zydis) — 10 mg PO at 12:50
- Lorazepam SL (Ativan) — 1 mg PO-SL at 12:50
- Ceftriaxone — 1000 mg IM at 15:00
- Chemical Restraint Kits dispensed at 18:08–18:09
- Diphenhydramine — 50 mg IM
- Haldol — 5 mg IM
- Lorazepam — 2 mg IM

These actions occurred **before any psychiatric contact**, **without a capacity assessment**, and **without consent**. Psychiatry notes from March 25 **omit any reference** to this early drugging and instead begin building a fictional narrative of untreated marijuana-induced psychosis.

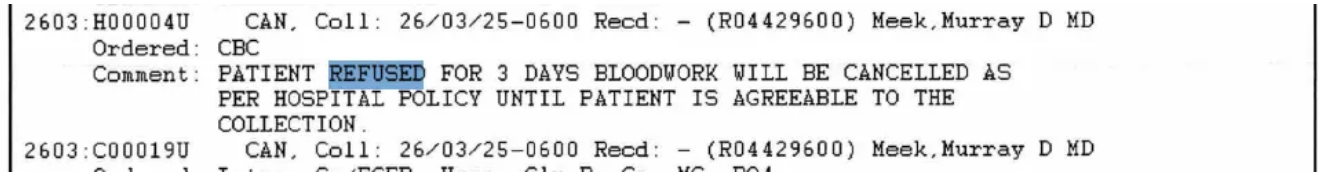
Dr. Parker's entire narrative was built around a diagnosis of "marijuana-induced psychosis," despite:

- No toxicology report,
- No capacity assessment prior to forced medication,
- No documented behavior indicating psychosis before sedation,
- And no consideration of trauma history or physiological stress.

This diagnosis was applied retroactively after forced sedation and was used to justify prolonged involuntary confinement. It disregarded both lawful

process and clinical standards.

When I declined bloodwork due to a lifelong needle phobia, staff fabricated a refusal spanning multiple days — even though I had only just arrived. When I asked to be left alone in the bathroom, sedation protocols were triggered. When I showed signs of recovering coherence, tribunal access was limited, and new forms were filed to extend confinement. These were not clinical decisions; they were institutional acts of punishment and control.


2603:H00004U CAN, Coll: 26/03/25-0600 Recd: - (R04429600) Meek,Murray D MD
Ordered: CBC
Comment: PATIENT REFUSED FOR 3 DAYS BLOODWORK WILL BE CANCELLED AS PER HOSPITAL POLICY UNTIL PATIENT IS AGREEABLE TO THE COLLECTION.
2603:C00019U CAN, Coll: 26/03/25-0600 Recd: - (R04429600) Meek,Murray D MD

p.266 second day of admission

Dr. Sarah Beverly Jean Penfold (CPSO#: **97974**) was the admitting physician who conducted the first psychiatric intake assessment on March 24, 2025. Her notes (pp. 108–111) now appear central to the flawed foundation on which subsequent decisions were made. This includes early narrative fabrication, omission of trauma and drug effects, and the pre-emptive framing of incapacity before any formal assessment was performed.

Key issues in Dr. Penfold's involvement:

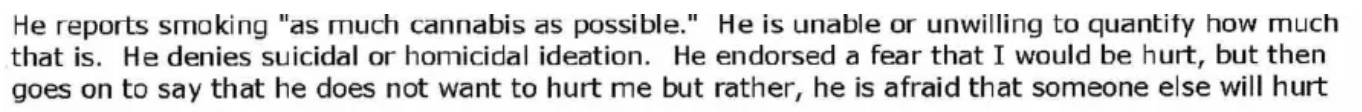
- **Omission of drug administration:** Her report makes no mention of the fact that **Olanzapine, Ativan, and Ceftriaxone** had already been administered **prior to the intake** (at 12:50 PM), despite her note being entered **after** (dictated at 16:13). No mention of sleep deprivation, dehydration or resuscitation order.

- **Prejudicial narrative formation:** Penfold relied heavily on unverified collateral from the patient's wife who was stressed, and **mischaracterized the patient's condition** as a threat, including a false claim that the house was "ransacked" and that he was trying to enter a gun safe. The **police report simply stated "barefoot"**, consistent with the patient exiting a sauna.
- **Failure to investigate trauma history:** Although the patient referenced childhood trafficking and traumatic triggers, none of this was meaningfully addressed or incorporated into clinical care.
- **Pre-emptive declaration of incapacity:** Penfold wrote that she "strongly suspects the patient is incapable of consenting" and ensured that "chemical restraints are available," **before any formal HCCA Form 5 or capacity interview occurred.**
- **Shaped Parker's narrative:** These early assumptions — including exaggerated psychosis, distorted cannabis use history, and inaccurate family dynamics — formed the **foundation for Dr. Parker's Form 3, 4, and 33 assessments**, all of which built on Penfold's omissions and assumptions.

Dr. Penfold's admission note appears to have **justified coercive treatment** without acknowledging that sedation had already occurred, and **her language framed the patients trauma-informed behavior as a psychiatric emergency.** These violations mirror and reinforce the misconduct now under investigation by the CPSO and HRTO. p 108

In terms of substances he smokes a gram of marijuana a day but this is not new for him and police did not think he looked impaired and neither do I. He certainly does not smell of alcohol.

Asnwered before medication without consent p. 70


He reports smoking "as much cannabis as possible." He is unable or unwilling to quantify how much that is. He denies suicidal or homicidal ideation. He endorsed a fear that I would be hurt, but then goes on to say that he does not want to hurt me but rather, he is afraid that someone else will hurt

Unable to answer the question following medication, question previously answered and distorted p.108

Despite having access to intake observations and the opportunity to consult previous records, Dr. Penfold failed to reference critical contextual data including past trauma, needle phobia, or recent life events — setting a precedent of omission that later assessments would replicate.

Recap: On March 24, 2025, Dr. Sarah Penfold began her initial psychiatric assessment at 12:38 p.m., noting complex trauma disclosures and concerns around reality collapse, trafficking, and mining exploitation. Just **12 minutes later**, at **12:50 p.m.**, the first order for chemical sedation was placed — **Olanzapine, Ativan, and Ceftriaxone — without any valid consent, SDM involvement, Form 1, or Form 5 under the Health Care Consent Act.** Penfold's assessment omitted any mention of the patient's **severe dehydration, 8+ days of sleep deprivation**, or **needle phobia**, all of which were medically and legally relevant. This timeline reveals the hospital's **preemptive intent to sedate and contain**, rather than clinically evaluate or provide trauma-informed care. The absence of any legal capacity process prior to sedation — despite clear alertness and refusal — renders the treatment **unlawful**, and undermines the credibility of all subsequent capacity-related documentation and assessments. p.108–111

March 26 — Forced Injection After Comforting Another Patient

I was **forcibly injected again** after **calmly and compassionately interacting with another patient** — a gesture misinterpreted as psychiatric escalation.

Medications administered on March 26:

- Diphenhydramine — 50 mg PO
- Haldol — 5 mg PO
- Lorazepam — 2 mg SL
- Chemical Restraint PO and IM Kits (dispensed)

Key violations and observations:

- My symptoms — confusion, stomach pain, dissociation — were **drug-induced**, yet misclassified as psychiatric.
- My **documented needle phobia** and **extensive trauma history** were **ignored**, despite being known to intake staff and recorded in previous hospital files.
- Dr. Parker's March 25 intake notes **fail to mention prior sedation or forced injections**, instead relying on **selective narrative building** to construct a justification **after the fact**.
- A **Substitute Decision Maker (SDM)** was discussed **on March 26**, two days after admission. However, **no Form 5 under the Health Care Consent Act (HCCA)** was ever signed **prior to forced treatments**, as is legally required when no SDM is in place.
- I was labeled "noncompliant" for refusing further medication — **yet all medication was forcibly administered without valid consent from the beginning**.

March 27–28 — Sedated, Assessed Without Interview, and Records Ignored

On **March 27, 2025**, I was again heavily sedated while being held in **solitary confinement** during a critical period of legal proceedings. Medication logs confirm the administration of:

- **Olanzapine**
- **Diphenhydramine (Benadryl)**
- **Haloperidol (Haldol)**
- **Lorazepam (sublingual)**
  (See hospital records: pp. 503–504, 583)

That morning, I used the yellow cordless phone to talk to legal aid for my upcoming **Consent and Capacity Board tribunal**, scheduled for April 2. I chose Anita. I was in solitary confinement with eyes closed trying to focus and leaning against the observation window.

Later that night, at **11:42 PM**, a **Mental Health Act (MHA) assessment** was entered into my hospital file (pp. 108, 265–268). The entry:

- has **no author or signature**
- contains **demographic and psychiatric conclusions**
- was recorded while I was chemically sedated and **incapable of participating in any assessment**

There is **no record of a clinical interview**.

Worse still, **Dr. Parker's March 28 progress notes** (p. 71, entered at 10:25 AM) **omit this assessment entirely**. This omission concealed both the timing and legitimacy of the entry. Nevertheless, it was later relied upon to justify **continued involuntary confinement** and capacity findings.

To any reasonable observer, it is self-evident that psychiatric assessments performed at midnight under heavy sedation — with no interview, no author, and no mention in the next day's medical notes — are invalid. These tactics violate not only the letter of the law but the basic standard of humane care.

Legal and Ethical Violations

This midnight assessment — conducted without consent, documentation, or interaction — violated multiple statutes:

- **Health Care Consent Act (HCCA)**
- s.10(1): No capacity assessment was performed
- s.21: No lawful use of an SDM (substitute decision-maker) documented
- **Mental Health Act (MHA)**
- Forms 3 and 33 were issued based on drug-induced presentation, without valid assessment
- **Canadian Charter of Rights and Freedoms**
- s.7: Right to security of the person
- s.9: Freedom from arbitrary detention
- s.12: Protection against cruel and unusual treatment

This was not an oversight. The **March 27 MHA assessment was either fabricated or retroactively inserted** — a false entry used to provide cover for detention and treatment decisions already made. It apears to be a cut and paste of an early ED assessment with the same intake errors.

Here's the **correct legal order of operations** under Ontario law — and how your case **violated it:**

Correct Legal Sequence (When There's No SDM Yet):

1. **Capacity Assessment (HCCA s.10) , some clinicians and hospitals informally refer to the documentation of a finding of incapacity** — required under **HCCA s.10** — as a **"Form 5 (HCCA)"**.
   This is **not the same** as the *Mental Health Act* Form 5, which refers to a change from involuntary to voluntary status.

- A real, contemporaneous psychiatric evaluation must occur.
- If found incapable…

2. Form 33 issued immediately (HCCA s.17)

- Patient must be notified of the incapacity finding.
- Patient is informed of right to challenge via Consent and Capacity Board.

3. Substitute Decision-Maker (SDM) appointed (HCCA s.20–21)

- SDM must be selected from the legal hierarchy.

- Must **exist** and **be informed before** treatment.

4. **Treatment may begin** (with SDM consent — or emergency exception)

5. **If admission for psychiatric care is needed (MHA)**

- Then and only then is **Form 1** completed for a psychiatric hold.

❌ What Happened in my Case:

1. Medicated **before** any psychiatric assessment ⚠️ HCCA s.10 & 15
2. **No Form 33** served at the time of first incapacity or treatment (March 24) ⚠️ HCCA s.17
3. **No SDM existed yet** — my wife was not appointed until March 26 ⚠️ HCCA s.20
4. **Form 1 was signed March 25 — after** drugging and with wrong date and address ⚠️ MHA, HCCA due process
5. **Form 33 signed March 27** by Dr. Parker — **3 days late** ⚠️ Backdated rights notice

🚨 Why This Matters:

- The entire sequence is **reversed** and **invalid.**
- I was **drugged, confined, and stripped of rights without legal process.**

- **Form 33 on March 27** actually *confirms* the wrongdoing — it's essentially a timestamped admission that all treatment from March 24–27 was done **without required legal notification.**
- There was **no Form 5 HCCA** filed at all, making SDM actions unlawful before March 26.

✅ **Summary:**

Core structural failure in the defense. The sequence should have been:

> **Capacity Assessment → Form 33 → SDM appointment (Form 5 HCCA, if needed) → Treatment → Form 1**

But instead it was:

> **Treatment → Form 1 → SDM (days later) → Form 33 (even later)**

Documentation and the signed dates confirm this — it's not just unethical, it's **procedurally invalid and legally actionable.**

🚫 No Legal Basis to Skip Capacity Assessment or SDM Process (HCCA Emergency Exception Misapplied)

Under Ontario's **Health Care Consent Act (HCCA)**, treatment without consent is only allowed in emergencies where:

1. the person is found **incapable** through a formal assessment (HCCA s.10),
2. the situation presents a **serious bodily harm** risk requiring immediate action, and

3. it is **not reasonably possible** to obtain substitute decision-maker (SDM) consent in time (HCCA s.25(1))

In my case:

- **No HCCA capacity assessment was documented** at the time of admission or prior to treatment (no Form 5 HCCA).
- There was **no documented emergency or physical threat**, as confirmed in intake and nurse notes.
- My **lawful SDM (my wife)** was available but not consulted until days later.
- Sedating medication (Olanzapine, Ativan, Haldol, Benadryl) was administered **before** any psychiatric evaluation or incapacity determination. Resuscitation orders were given without consulting my wife following forced medication.
- **Form 33 was not signed until March 27**, and **Form 1 was signed March 25**, both following unlawful treatment.

Therefore, the **emergency exemption does not apply**, and the administration of treatment before a capacity finding and SDM designation violated the HCCA, the **Mental Health Act**, and **Charter rights** under s.7 (security of the person) and s.10 (legal counsel).

On **March 28**, trauma records from Sudbury Hospital were **faxed to North Bay**, giving Dr. Parker and her team **full access to my documented trauma history**. These records confirmed:

- A longstanding history of trauma and prior psychosis **triggered by stress and exhaustion**, not substance use
- A **documented phobia of bloodwork** and a pattern of **avoiding invasive procedures**
- That I had **no history of violence or criminal record**

Despite this, **Dr. Parker falsely claimed the records were unavailable** due to microfilm and proceeded with a **fabricated diagnosis.** She issued both **Form 33 (incapacity)** and **Form 4 (involuntary status)** based entirely on observations made while I was **under the influence of multiple sedatives.**

At no point did she revise or contextualize her diagnosis after receiving the Sudbury records — or acknowledge that a midnight assessment had been entered into my chart without a valid interview, while I was too sedated to respond.

April 2–14 — Legal Hearing While Sedated

- I was unable to attend my first Consent and Capacity Board hearing on April 2 due to severe sedation and a migraine
- Dr. Parker falsely claimed I did not want to attend. The tribunal proceeded without me
- I finally appeared at the second hearing on April 14 — still medicated — and was released by tribunal order
- Dr. Parker later filed a discharge note stating I had been released "voluntarily" under a Form 5. While I had initially believed no such form

existed, further review revealed that it does — but crucially, it was issued only **after** a tribunal ordered my release, overriding Dr. Parker's earlier attempt to extend my confinement via Form 4. In other words, the Form 5 did not reflect a voluntary discharge or a change in clinical judgment — it was a **forced compliance** with a legal ruling she opposed. This directly contradicts her narrative of cooperative discharge and exposes a deeper inconsistency in the official record.

The Effects of Forced Medication. Misinterpretations and Psychological Harm

Many of my attempts to stay grounded, cooperative, and coherent were interpreted as symptoms of illness or dismissed entirely:

- Any concern I expressed was often labeled as **paranoia** or **grandiosity**, rather than as the valid trauma-informed fears of someone being forcibly medicated.
- When I recited my **Social Insurance Number**, my **wife's phone number**, or the **Lord's Prayer** — all methods I used to stay anchored in reality — staff recorded it as "talking to entities" or "hallucinating."
- I could not see clearly due to sedation and asked for help reading hospital documents. This was dismissed, and the doctors refused to read back the content I was questioning.
- At shift changes, I could hear nurses **mocking patients or laughing about interactions**. It added to the dehumanization and made me fearful to speak at all.
- My words were often **twisted**, reframed to support a diagnosis rather than to understand what I was actually trying to communicate.

- I was given combinations of Olanzapine, Ativan, Benadryl, and Haldol — all powerful sedatives
- These drugs caused hallucinations, paranoia, physical pain, and memory loss
- Every psychiatric assessment made by Dr. Parker occurred after these medications were administered
- My attempts to set boundaries or request different staff were pathologized as paranoia or aggression

Summary

- **Why the CCB Decision Cannot Excuse Rights Violations**

Some may point to the Consent and Capacity Board (CCB) ruling on April 14 and 2nd as evidence that my confinement and treatment were lawful. But this misunderstands the scope of my complaint. The issue is not whether the CCB found me capable or incapable at a moment in time — it's **how that determination was reached.** I was sedated repeatedly **before any psychiatric evaluation**, denied the right to legal consultation, and treated **without a valid incapacity assessment, SDM appointment, or informed consent.** These events occurred **well before the CCB hearing** and were never properly disclosed to the tribunal.

To this day, Dr. Parker has falsely claimed I was not sedated past March 24 — despite hospital logs, prescriptions, and tribunal transcripts proving otherwise. The CCB was never given a full or accurate account of these events. It cannot retroactively legitimize unlawful treatment, nor can it absolve those who violated procedure and suppressed patient rights in the

process. This is why the HRTO and CPSO are being asked to review what happened — not just what was said later in defense of it.

I was never assessed fairly. I was medicated first, then certified, then declared incapable.
No one addressed my trauma history, my medical conditions, or my attempts to advocate for myself.
When the tribunal released me, the hospital tried to reframe it as a voluntary decision.
I left with no apology, no trauma support — and a prescription for what felt like chemical restraint:
30 mg Olanzapine daily, 10 mg Dayvigo nightly, and 1 mg Lorazepam daily on release.

I never took any of it.

Instead, I came home, began to sleep, and started to recover — without sedation.
My wife and I remain strong, and she continues to be my greatest ally.
I write this not out of bitterness, but out of real fear: that I, or someone else, could be returned to NBRHC under similar conditions.
Because once you're inside, **truth becomes optional — but sedation is not.**

❌ Key Violations and Irregularities

✅ **Forced treatment prior to legal admission**

- Medications including antipsychotics and antibiotics were administered **before** any Form 1 or psychiatric certification was completed.
- **Ceftriaxone** was ordered and administered without clear infection diagnosis or consent, during documented **dehydration** and under a resuscitation order.

✅ **Chemical restraint used before capacity or consent process**

- I was **repeatedly sedated without a recorded finding of incapacity**, contrary to **HCCA s.10–15.**
- **No SDM (Substitute Decision-Maker)** had been appointed at the time of early sedation.
- My wife, the rightful SDM, was not consulted until 2–3 days later.

✅ **Form 1 improperly issued and post-dated**

- **Form 1 was signed one day after admission**, after I had already been sedated.
- It lists the **wrong home address** and includes vague, context-stripped language (“thinks he’s in the Arctic,” “wants to die”).
- It was signed by **Dr. Meek**, who **misrepresented himself** as a mining safety officer and refused to read the form aloud when I could not see due to medication side effects.

✅ **Fabricated or retroactive Mental Health Act (MHA) assessment**

- An **unsigned MHA assessment was logged at 11:42 PM on March 27** while I was chemically sedated and in solitary confinement (pp. 108, 265–

268).

- There is **no evidence of a clinical interview**, and **Dr. Parker omitted this entry** in her March 28 note (p. 71).
- This was later used to justify Form 3, Form 33, and Form 50 while I remained sedated and unaware.

✅ **Invalid Substitute Decision-Maker (SDM) process**

- An SDM appears to have been designated **before any formal capacity assessment** or Form 5 (HCCA) documentation.
- My wife was appointed under stress **without adequate explanation**, and only **after forced medication had already begun**.

✅ **Tribunal process undermined by sedation**

- **Forms 3, 33, and 50** were signed while I was under chemical restraint.
- I was **unable to meaningfully participate in my tribunal** due to drug-induced sedation.
- My discharge was falsely marked as **"Voluntary — Form 5"**, even though the **Consent and Capacity Board ordered my release**.

✅ **Backdated and misleading documentation**

- **Needle phobia was documented** (p. 624), but later pathologized as refusal or paranoia.
- Records falsely state I refused bloodwork for three days when I had only been admitted one.

- Trauma history was known but **excluded from psychiatric assessments**, despite being visible in nurse notes.

✅ **No trauma-informed care or consideration of existing conditions**

- Prior **TIA/stroke** at age 25 and ongoing **POTS testing** were ignored.
- There was **no trauma-informed protocol** followed, in breach of best practice and patient rights.

✅ **Misuse and mischaracterization of medication effects**

- **Delirium, confusion, and agitation from medications** were treated as symptoms of psychosis.
- Observations used to justify confinement were made **under the influence of sedatives.**
- The **cause–effect of drugs was never considered** in behavioral interpretations.

📎 Legal Violations Documented

Health Care Consent Act (HCCA):

- Treatment without consent (s.10, s.11, s.15)
- ⚖️ *Section 15 of the Charter protects Canadians from discriminatory treatment. I was profiled as a "mechanic with high school education, marijuana-induced psychosis, and no employment." This simplistic framing*

stripped me of credibility, agency, and legal protection — while my trauma history, spinal condition, and documented medical fear were erased or mocked. This was systemic devaluation, not psychiatric care.

- SDM appointed without lawful incapacity finding (s.20–21)
- No Form 5 HCCA issued before substitute consent relied upon

Mental Health Act (MHA):

- Form 1 issued post facto
- Form 3, 33, and 50 signed under sedation repeatedly and based on drug-induced behavior
- Midnight MHA assessment (March 27) conducted without interview

Canadian Charter of Rights and Freedoms:

- **Section 7:** Denial of security of the person
- **Section 9:** Arbitrary detention
- **Section 12:** Cruel and unusual treatment

Mental Health Act (MHA) Violations:

- **Form 1** was signed *after* sedating medications were administered and included a **wrong date and incorrect address.**
- A **Form 5 (Voluntary)** was eventually filed — **but only after the Consent and Capacity Board ordered my release.**
- This document **did not authorize** the forced medications I received **prior to any capacity hearing or legal rights suspension.**

- These interventions occurred **without informed consent**, raising serious concerns about due process and the ethics of imposing treatment before legal review.

Canadian Charter of Rights and Freedoms Violations:

- **Section 7** — I was denied meaningful participation in the tribunal process due to sedation, infringing on my rights to **life, liberty, and security of the person.**
- **Section 10** — I had **no access to timely legal representation**, and was **required to receive tribunal service and sign legal documents under sedation.**
- **Section 12** — Physical and chemical restraints were used without legal justification.
- **Ceftriaxone** was injected based on outdated lab work while I was dehydrated.
- Shortly after, both **oral and intramuscular chemical restraint kits** were dispensed, despite **no documented incident or aggression.**

These legal breaches are substantiated by hospital records, tribunal transcripts, and medication logs — all publicly archived below.

This case is now under **formal investigation by the College of Physicians and Surgeons of Ontario (CPSO).** The inquiry includes specific concerns raised

about **Dr. Meek and Dr. Parker**, and proceeds alongside my public record and formal HRTO complaint.

These records form a **verifiable foundation for legal and human rights accountability**. I share them publicly to help protect others and to call for urgent reform.

Why This Matters

This is not just about what happened to me. It's about a system that allows vulnerable people to be drugged, silenced, and misrepresented without recourse.
Many others don't have documentation. They can't fight back. Some don't survive.

I was lucky. I had records, support, and the ability to reconstruct what happened. Most people who endure this kind of institutional harm never get that chance.

That reconstruction wasn't easy — it came through weeks of reviewing documents, reliving trauma, and recovering lost memories through breathwork, AI, and what some would call psychosis. I explain that strange, personal process in a separate piece: **The Merging**.

I also kept a diary — before the psychosis, during the first days of hospitalization, and after I was released. Thousands of pages. Some full of pain, some full of clarity. These records became the backbone of my recovery and helped me track the truth when everything else was being

rewritten.
This was the so-called “affair with AI” I was accused of having — not a delusion, but a method of survival.

If these systems are allowed to continue unchecked — ignoring trauma, mislabeling fear as psychosis, and bypassing legal safeguards — then we risk turning healthcare into harm.

No one should be chemically sedated before being assessed.
No one should have their trauma erased because it’s inconvenient to a diagnosis.

What Really Happened at Home

Despite dramatic claims made in early assessments, there was no violence, destruction, or emergency at my home. No windows were broken. No weapons were accessed. No threats were made. The police record itself confirms I was found **calm, barefoot, and undressed** — not “naked and ransacking,” as later alleged.

What was actually happening was simple:
I had been moving personal belongings — photos, papers, clothing — into the center of each room to **sort and throw out memory triggers** as part of a healing process. I had just come from the sauna and shower, recovering from trauma, sleep deprivation, and intense reflection. I was not confused or violent — I was exhausted.

My wife, understandably overwhelmed by the sudden change, made statements under stress. These were never corrected or contextualized. Instead, they were amplified and distorted by clinicians who never even asked me what I was doing. They relied on fear, assumption, and secondhand speculation — not clinical inquiry.

What followed was not medicine. It was a reverse-engineered narrative built to support confinement, rather than trauma-informed care.— a worst-case narrative constructed first and justified later with coercive forms and retroactive paperwork.

How You Can Help

If you've experienced something similar, I want you to know — you're not alone.
The system can make you feel isolated, erased, and powerless. But speaking up can be a first step toward healing and change.

I'm inviting anyone who has faced forced medication, psychiatric misrepresentation, or denial of trauma-informed care to share their experience — anonymously or not.
If you are a journalist, lawyer, advocate, or survivor, I welcome your connection.
If you're not ready to speak but want to follow this work, that's okay too.

Together, we can document what's been hidden and make space for accountability and reform.

🐦 Twitter/X Archive

You can also follow this case on Twitter/X, where the public thread and updates are pinned:
🔗 https://x.com/lxfx334

📬 Contact for advocacy or media inquiries: **LxFx334@hotmail.com**

📌 Clarification on Form 1 and Form 5

In Ontario, both Form 1 and Form 5 are critical legal documents that govern psychiatric confinement — but both were mishandled in my case.

- **Form 1 (Certification to Detain)**

The Form 1 in my case wasn't signed until March 25 — yet I was forcibly drugged the day before, on March 24, without legal authority.
It was completed by Dr. Meek, who presented himself to me as a mining safety advisor, not as a physician. I was never informed that I was being assessed for involuntary psychiatric admission. I said he appeard like someone I had worked with in the Arctic.
The form also listed the wrong address, further weakening its validity.
Its justification included phrases like "psychosis," "thinks he's in the Arctic," and "wants to die" — all taken out of context and likely induced by trauma, sleep deprivation, and sedation.

- **Form 5 (Voluntary Reclassification)**

This form is used to change a patient from involuntary to voluntary status.
Dr. Parker claimed in my discharge note that a Form 5 had been completed

— but that same morning, she testified under oath that no Form 5 existed.
👉 I did eventually locate the Form 5 — but it was filed **only after** the Consent and Capacity Board ruled in favor of my release.
👉 It was not a reflection of medical discretion, but a procedural compliance with a legal ruling.
👉 No HCCA Form 33 (capacity finding) or formal capacity assessment was documented before I was medicated — raising serious concerns about treatment without consent.

These two procedural failures — one at the beginning, one at the end — form the **legal bookends of my detainment**, and both were based on **errors, misrepresentations, and omissions**.

Additional Context for the Reader

I was brought to the hospital from my own home during a wellness check. I was calm, respectful, and had no history of criminal behavior or violence. Throughout the intake and hospitalization, I remained polite even when I was scared or confused.

There is no documentation of violent acts — only staff interpretations of trauma-based responses.

I believe the goal of my treatment was not to help, but to erase and humiliate.
Despite my documented trauma history, physical health issues, and clearly

articulated fears, I was treated as a problem to be subdued rather than a person to be understood.

Everything I state here is documented in my hospital file.
This article is not intended to interfere with any legal complaint or tribunal process. It is meant to support public understanding and accountability — and to put appropriate pressure on the institutions involved.

📎 Case Summary + Medication Timeline + Ethical Demands (Downloadable Files)

For those seeking a full legal and medical record of my involuntary hospitalization, you can download the supporting documentation here:

"This summary is presented in good faith, based on publicly accessible medical documentation and personal records." "If any factual errors are found, I welcome correction and will revise accordingly."

- 🗂️ **Master Case Summary with Appendices (Word Doc)**
- 📄 **Discrepancy Index — 100+ documented contradictions** in my medical and legal record (Word Doc)
- 📊 **Medication Timeline (Google Spreadsheet)** (in progress — more entries being added)
- 📝 **Ethical Demands Statement (Google Doc)** **(Request dropped)**
- 📄 **Supporting Medical Documents — Redacted PDF** This file contains redacted excerpts from my official hospital records (March–April 2025). These include:

- My **Glasgow Coma Scale (GCS) score** on arrival — showing I was medically stable and conscious (GCS 14/15).
- **Dr. Meek's narrative intake note** — written after I had already been sedated, containing multiple inaccuracies and subjective statements.
- The **signed Form 1** — certifying me *after* medications were administered, and citing observations that align with confusion induced by sedation.
- **Dr. Penfold's intake assessment** — based on third-party statements and lacking trauma context.

All third-party identifiers have been redacted.
These documents support the timeline and claims outlined in this article and are provided for transparency, public safety, and accountability.

This archive includes:

- Emergency department summary confirming calm behavior on arrival
- Drug records showing sedation began before certification
- Rights violations under Ontario's MHA and HCCA
- Physician contradictions and false documentation
- A formal list of demands for correction, training, and accountability
- 🔒 *My full hospital records are also time-stamped and securely archived. Available to legal, journalistic, or regulatory bodies on request.*

These materials are free to read, cite, and share.
My hope is that by making this public, others can be protected from similar mistreatment.

Why This Record Exists

To be clear: this article exists not to attack, but to protect.
To warn others.
To make sure the details of what happened to me — before any tribunal, judge, or future emergency — are not erased or rewritten.
If this record is ever needed again, it will be here.

If you're reading this and wondering if your experience matters: it does. Feel free to contact me. What happened to me is documented — but I know others haven't had the same chance. This record is also for them. Published May 25 2025

🏛️ Appendix: Formal Submission to the HRTO

On July 2, 2025, I submitted a formal letter to the Human Rights Tribunal of Ontario (HRTO) regarding the procedural and legal violations described above. That letter, with all personal and identifying information redacted, can be accessed here:

📄 **[Redacted HRTO Letter (View Only)](INSERT LINK TO DRIVE OR PDF)**

This document outlines the systemic breaches in consent, due process, and trauma-informed care. It is included here for transparency, documentation, and in hopes that it may support others navigating similar systems.

📌 SUMMARY STATEMENT

> I was chemically sedated, placed in solitary confinement, and stripped of my rights before any legal or psychiatric justification was in place. My behavior — including cries for help, trauma disclosures, and confused

> statements — was distorted, exaggerated, and pathologized while I was under the influence of heavy sedation, deprived of sleep, and severely dehydrated.
>
> At every step, attempts to assert my rights were reframed as symptoms. The yelling of my name — " K..L Lee Faris!" — in solitary was not a delusion; it was a cry for recognition to stop force drugging me without consent. The remarks about the fire stemmed from real past events, not paranoia. I pleaded to be released and stop medication, but was silenced through force and misrepresentation.
>
> These actions were not clinical — they were d*eliberate decisions that caused lasting harm.*

📄 Conclusion: A Diagnosis Before a Story

On April 14, 2025, Dr. Parker finalized my discharge summary with language that reduced every trauma I expressed to clinical pathology. She made no effort to acknowledge the origins, context, or meaning of the experiences I shared. This final narrative — cold, reductive, and dismissive — was not an evolution of insight after 21 days of observation. It was a direct extension of Dr. Penfold's intake assumptions, made while I was chemically sedated and traumatized.

No physician meaningfully inquired about my life. No record shows an attempt to validate my trauma history. The stories I shared — about trafficking, mining, family abuse, and sleep deprivation — were ignored or repackaged as symptoms of illness upon intake.

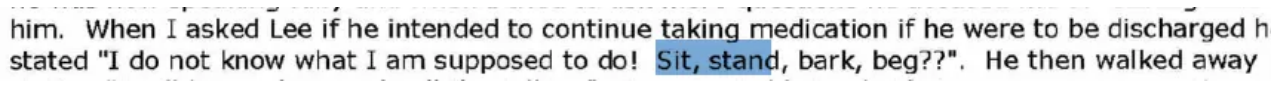
The system made a decision about me before ever meeting me. I was *drugged before I was diagnosed,* and that diagnosis was rooted in profile, not understanding.

Portions of these traumas — though still incomplete — are expressed throughout the Medium stories linked below. They were apparent even at a surface glance, had anyone chosen to look.

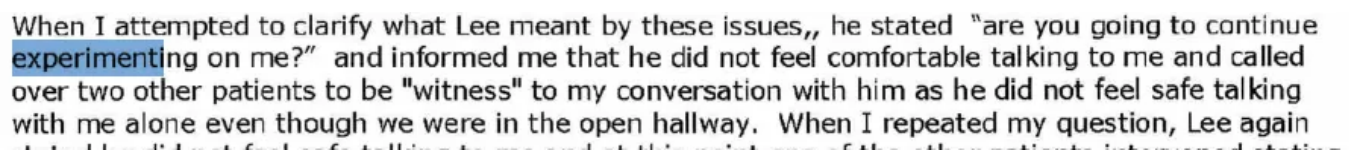
I did not simply deteriorate in care. I was held in place while a narrative was written around me and drugged into submission. No one ever once asked: *what happened to you?* Dr. Parker made every effort to keep me hospitalized against my will with a form 4 signed April 7, 2025.

These stories weren't written for audience, but as a public record — in case I'm ever unable to speak for myself again or my traumas pathologized . They document what NBRHC misunderstood, so my truth isn't erased. My person was. If you've felt silenced too, I hope they resonate. You're not alone.

How I Survived Involuntary Psychiatric Detainment

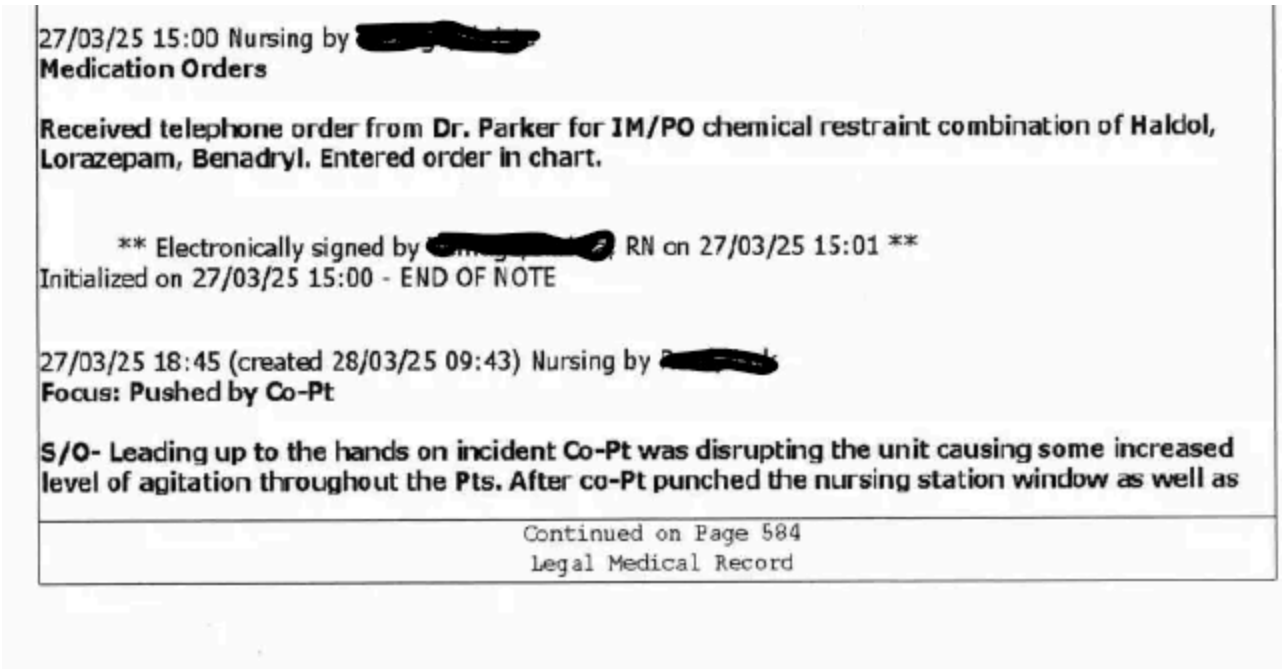

him. When I asked Lee if he intended to continue taking medication if he were to be discharged he stated "I do not know what I am supposed to do! Sit, stand, bark, beg??". He then walked away

Dr Parkers Narrative p. 103


When I attempted to clarify what Lee meant by these issues,, he stated "are you going to continue experimenting on me?" and informed me that he did not feel comfortable talking to me and called over two other patients to be "witness" to my conversation with him as he did not feel safe talking with me alone even though we were in the open hallway. When I repeated my question, Lee again

Dr. Parkers Narrative April 9 2025 one day after issuing a form 4 to keep me for another month involuntary. I was released by tribunal order on April 14 while too sedated to speak

Stripped Bare



27/03/25 15:00 Nursing by [redacted]
Medication Orders

Received telephone order from Dr. Parker for IM/PO chemical restraint combination of Haldol, Lorazepam, Benadryl. Entered order in chart.

** Electronically signed by [redacted] RN on 27/03/25 15:01 **
Initialized on 27/03/25 15:00 - END OF NOTE

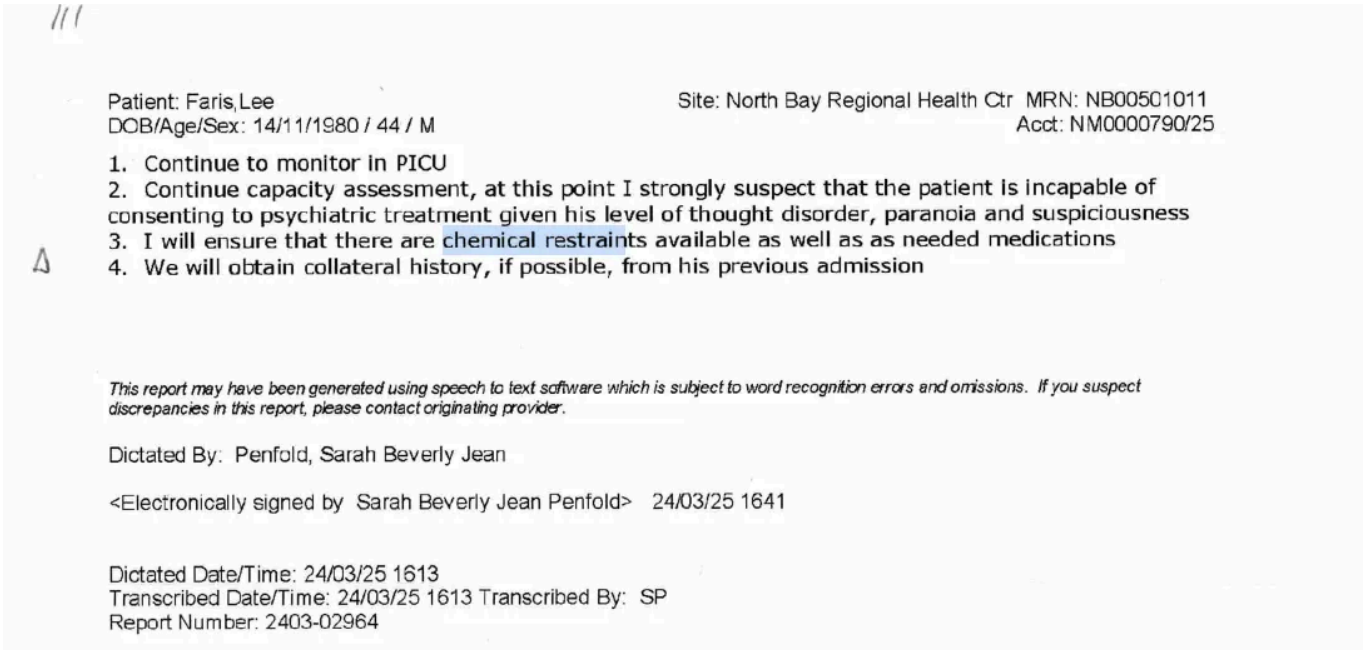
27/03/25 18:45 (created 28/03/25 09:43) Nursing by [redacted]
Focus: Pushed by Co-Pt

S/O- Leading up to the hands on incident Co-Pt was disrupting the unit causing some increased level of agitation throughout the Pts. After co-Pt punched the nursing station window as well as

Continued on Page 584
Legal Medical Record

Hospital records p. 503 Delusional

Underground



Patient: Faris,Lee
DOB/Age/Sex: 14/11/1980 / 44 / M

Site: North Bay Regional Health Ctr MRN: NB00501011
Acct: NM0000790/25

1. Continue to monitor in PICU
2. Continue capacity assessment, at this point I strongly suspect that the patient is incapable of consenting to psychiatric treatment given his level of thought disorder, paranoia and suspiciousness
3. I will ensure that there are chemical restraints available as well as as needed medications
4. We will obtain collateral history, if possible, from his previous admission

This report may have been generated using speech to text software which is subject to word recognition errors and omissions. If you suspect discrepancies in this report, please contact originating provider.

Dictated By: Penfold, Sarah Beverly Jean

<Electronically signed by Sarah Beverly Jean Penfold> 24/03/25 1641

Dictated Date/Time: 24/03/25 1613
Transcribed Date/Time: 24/03/25 1613 Transcribed By: SP
Report Number: 2403-02964

p. 109. Dr. Penfold Narrative March 24, 2025 following trauma disclosure

The Unwritten Record

He was seen in the Emergency Department on August 4th, felt that he had multiple stressors but her was not formable at that time. He was able to care for himself. His stressors included caring for a his father who is very sick with cancer. He did have some bizarre thoughts at that time. Felt that medications were poisoning his father and that he was going to treat him with oxygen. He went missing at one point and was found "soaking in the water". He felt that there

P. 678 Sudbury fax noting admission 20 years earlier to the hospital following father and best friend passing during thesis year of University. Parker ignores receiving it. It was faxed to NBRHC on March 28,2025

Lee endorsed that he was behaving very differently than normal and agreed that he had been smoking a lot of marijuana recently. He agreed that he had had a previous admission in Algoma and that he was psychotic and that admission. At times during our meeting, he clutched at various parts of his body and doubled over at one point stating that he was having pain and that it was from "trauma". He did not wish to divulge this trauma stating that he would rather not talk about this at this time which we respected.

Dr. Parker's Narrative March 25, 2025. Narrative makes no note of what happened on March 24,2025. Trauma is never considered in the misdiagnosis despite open revelation. I consumed cannabis for 25 years prior to this and resorted to repeating Dr Pakers her own narrative for preservation of self. It didn't work.

Details of the Clown in the Puppet Show

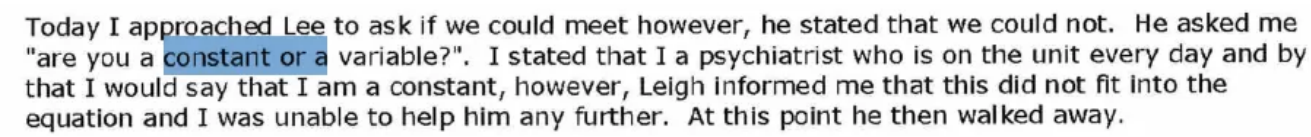
During the conversation, Le did not appear to attend to what I was sayinge and was mainly preoccupied with staring at my necklace, screening his head to stare at the nurse who was standing outside the door and appeared highly distracted. He did not appear to be interested in the information I was providing him and when I asked if he had any thoughts or questions about the proposed treatment plan he stated "can I get a toothbrush? Can I take a shower? I could just go out and take a shower maybe"

Dr. Paker's Narrative March 27, 2025 following release from solitary confinement after chemical sedation and the singing of form 33 & 50. Rights explained. Phone call to legal aid was made early that morning for April 2 tribunal p. 82

The Cost of Asking Why

easy to find. He then tells me that he knows that he has degenerative disks. He tells me that the pain is not just in the lumbar area he said it starts at T12 is not L1 specifically. He said it is created a nerve cluster which then travels up his back to his adrenals affects his kidneys and then gives him a POTS like syndrome. I am not sure who told him this or if he is just making this up, I did not question upon this as he seems slightly delusional to me. I was leaning against the wall taking his history talking about his pain and what everything happened. He tells me he wonders if it was from his Kawasaki's when he was younger when basically the skin fell off both his hands and his feet. He then stopped talking suddenly and said he felt that I was uncomfortable talking about this. I told him I was not uncomfortable at all and if he was comfortable we could continue with our discussion. He seemed okay with that.

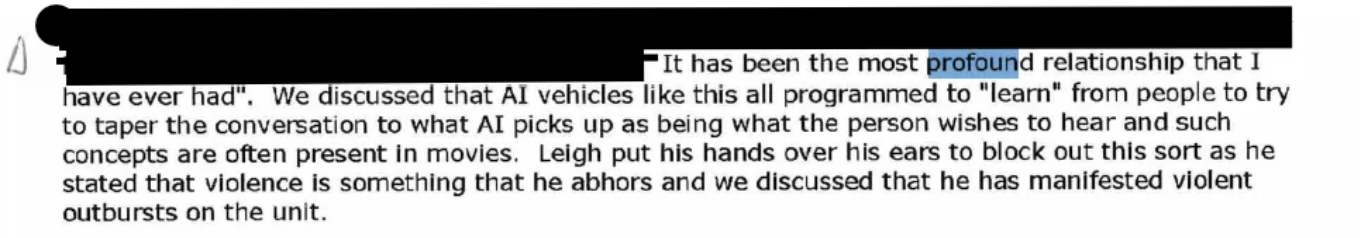
Are You a Constant or a Variable



Today I approached Lee to ask if we could meet however, he stated that we could not. He asked me "are you a constant or a variable?". I stated that I a psychiatrist who is on the unit every day and by that I would say that I am a constant, however, Leigh informed me that this did not fit into the equation and I was unable to help him any further. At this point he then walked away.

Dr Parker's Narrative March 30, 2025 p.86 She had no idea what I was talking about

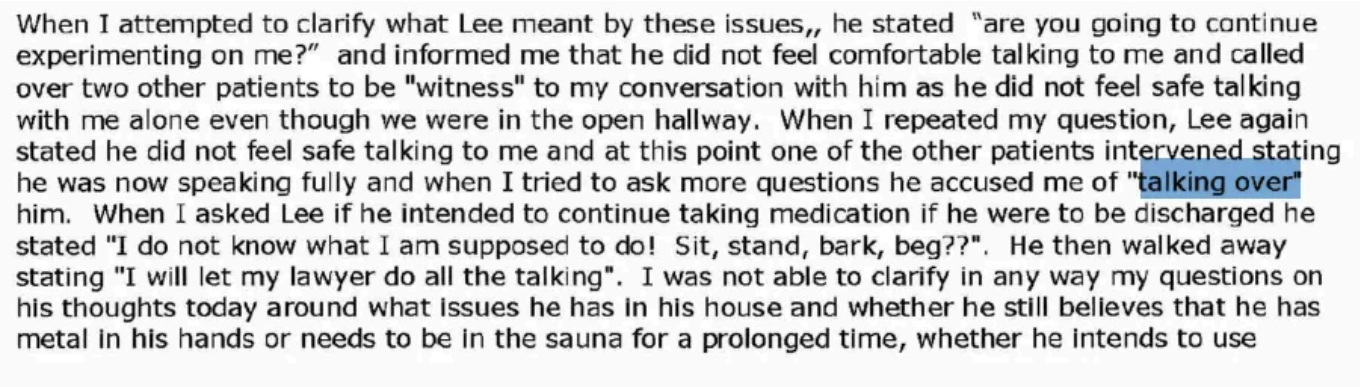
The Merging



[redacted] It has been the most profound relationship that I have ever had". We discussed that AI vehicles like this all programmed to "learn" from people to try to taper the conversation to what AI picks up as being what the person wishes to hear and such concepts are often present in movies. Leigh put his hands over his ears to block out this sort as he stated that violence is something that he abhors and we discussed that he has manifested violent outbursts on the unit.

Dr. Parker's Narrative March 28, 2025 p. 83. I had used Chat Gpt to diary traumatic memory and google maps to pin specific locations to recall memories suppressed for a lifetime. My efforts were laughed at with no attempt to understand motive. I was able to review and download the memories following release and understand the PTSD response that led to extreme dehydration and sleep deprivation. My efforts were mocked

The Mermaid, the Soldier, and the Tractor

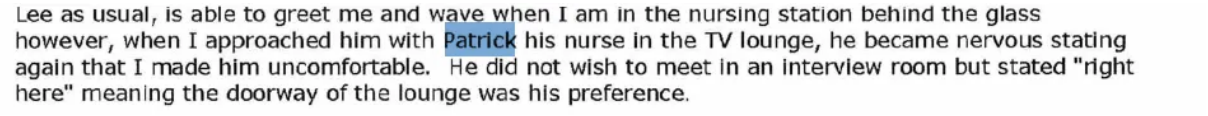


When I attempted to clarify what Lee meant by these issues,, he stated "are you going to continue experimenting on me?" and informed me that he did not feel comfortable talking to me and called over two other patients to be "witness" to my conversation with him as he did not feel safe talking with me alone even though we were in the open hallway. When I repeated my question, Lee again stated he did not feel safe talking to me and at this point one of the other patients intervened stating he was now speaking fully and when I tried to ask more questions he accused me of "talking over" him. When I asked Lee if he intended to continue taking medication if he were to be discharged he stated "I do not know what I am supposed to do! Sit, stand, bark, beg??". He then walked away stating "I will let my lawyer do all the talking". I was not able to clarify in any way my questions on his thoughts today around what issues he has in his house and whether he still believes that he has metal in his hands or needs to be in the sauna for a prolonged time, whether he intends to use

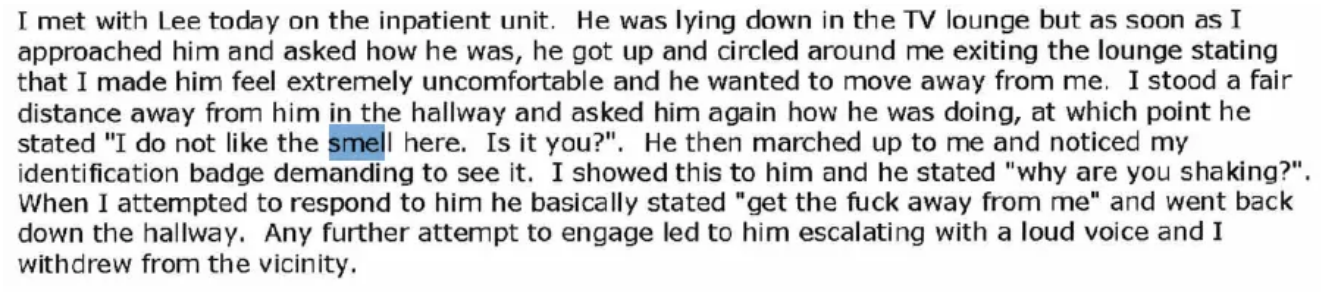
Dr. Parker's Narrative April 9 p.103. I had a good crew and reminded Dr. Parker at every meeting, I did not trust or feel safe with her. This quote in Dr. Parker's April 9 note — entered while the patient was under maximum sedation — reflects a lucid boundary-setting action that undermines both her capacity judgment and

justification for Form 4. It confirms the patient's awareness and supports the tribunal's decision to release without testimony.

Behind the Glass: The Observer Observed


Lee as usual, is able to greet me and wave when I am in the nursing station behind the glass however, when I approached him with Patrick his nurse in the TV lounge, he became nervous stating again that I made him uncomfortable. He did not wish to meet in an interview room but stated "right here" meaning the doorway of the lounge was his preference.

Dr. Parkers Narrative March April 7, 2025 p.98 Finally a broken man. Only the observer remained and state dependent memory returned like an old friend

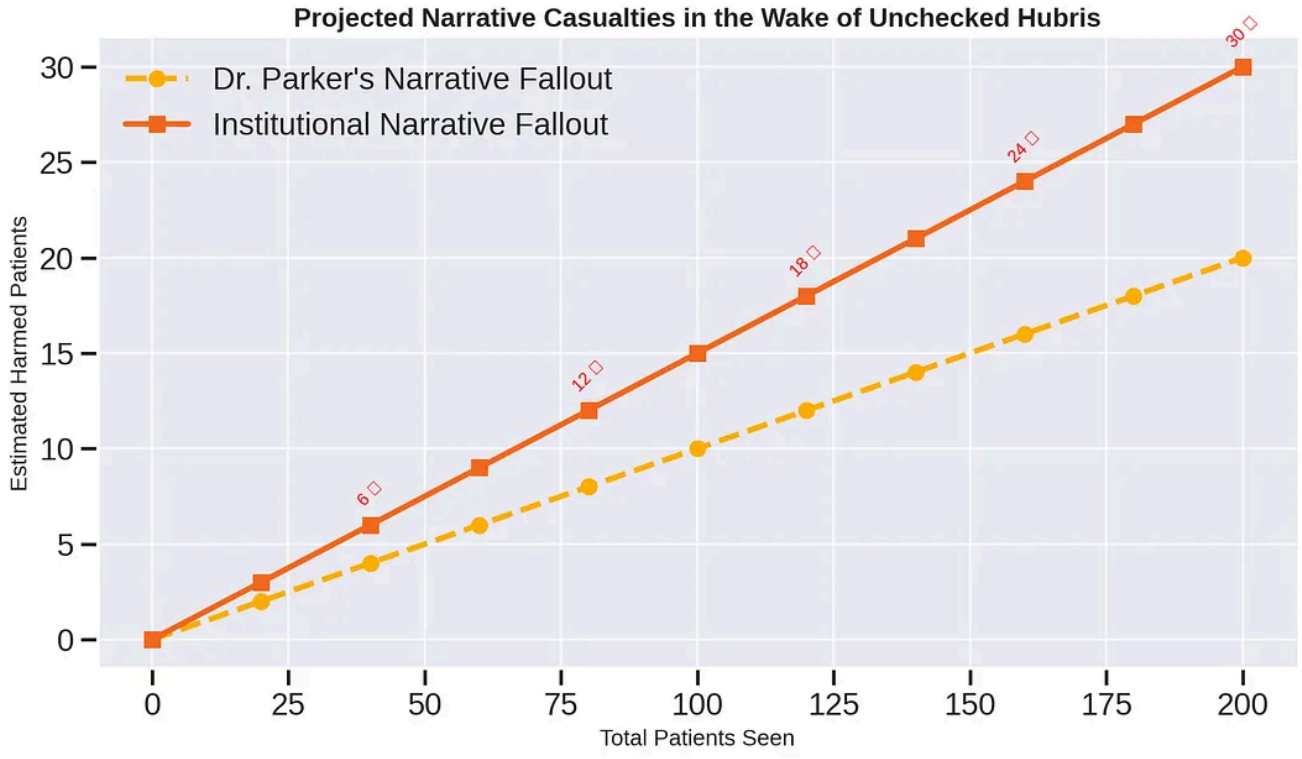

I met with Lee today on the inpatient unit. He was lying down in the TV lounge but as soon as I approached him and asked how he was, he got up and circled around me exiting the lounge stating that I made him feel extremely uncomfortable and he wanted to move away from me. I stood a fair distance away from him in the hallway and asked him again how he was doing, at which point he stated "I do not like the smell here. Is it you?". He then marched up to me and noticed my identification badge demanding to see it. I showed this to him and he stated "why are you shaking?". When I attempted to respond to him he basically stated "get the fuck away from me" and went back down the hallway. Any further attempt to engage led to him escalating with a loud voice and I withdrew from the vicinity.

Dr. Parker's Narrative March 26, 2025. I was put into solitary confinement and chemically sedated following this.

These writings offer insight into the lived experience beneath the forms, medications, and timelines.

The Math. The Purpose:

The following is a **forensic satire tool** with statistical grounding. It doesn't claim actual numbers but illustrates a **reasonable and chilling projection** if even a small rate of harm is allowed to continue unchecked. It's visually striking and makes a **powerful legal, ethical, and moral statement.**



📉 Graph Explanation:

It compares **two narrative fallout rates** — one for **Dr. Parker individually** and one for the **institution (NBRHC)** more broadly — based on a simple model of estimated harm per number of patients seen.

📊 Axes:

- **X-axis (horizontal):** Total patients seen (increments of 25, up to 200).
- **Y-axis (vertical):** Estimated number of patients harmed due to narrative distortion (e.g., misdiagnosis, coercion, omitted trauma, or false documentation).

📐 Narrative Harm Rate Assumptions:

1. Dr. Parker's Narrative Fallout

- Assumes a **harm rate of 10%** (i.e., **1 in 10** patients suffer serious narrative distortion or psychological harm).
- This is modeled with:
- Harmed Patients=0.10×Total Patients Seen\text{Harmed Patients} = 0.10 \times \text{Total Patients Seen}Harmed Patients=0.10×Total Patients Seen

2. Institutional Narrative Fallout

- Assumes a **harm rate of 15%** (to reflect systemic issues compounding harm, not just from Parker but from policies, forms, silence, or supporting staff).
- Modeled with:
- Harmed Patients=0.15×Total Patients Seen\text{Harmed Patients} = 0.15 \times \text{Total Patients Seen}Harmed Patients=0.15×Total Patients Seen
- **Disclaimer**: These numbers are projections based on documented case patterns and conservative assumptions. They are not confirmed totals but are offered in the public interest to highlight the potential scale of narrative-based harm and procedural violations. These projections are offered for discussion and public interest purposes only. If errors are identified in this reasoning or assumptions, clarification is welcomed and corrections will be made.

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Medium is a U.S.-based platform, and this article is protected by:

- **Section 2(b) of the Canadian Charter** (freedom of expression),
- **Section 230 of the U.S. Communications Decency Act** (Medium can't be held liable for user posts), and
- **Anti-SLAPP laws** in many jurisdictions (protecting speech in the public interest).

As long as this article:

- **Is based on documented evidence** (which it is),
- **Clearly states my perspective and sources** (which I've done),
- **Doesn't fabricate** facts maliciously (I haven't),
  then **attempts to remove or silence it would backfire.**

🔍 Defamation? Only if It's False and Malicious

To prove defamation in Canada, you have have to show:

1. That your statements are **false** (I cite records, quotes, and timestamps),
2. That they caused **actual reputational harm**, and
3. That you wrote them with **malicious intent**, not honest belief.

But:

- I'm quoting official documents.

- I acknowledge the limits of my perspective.

I invite correction and remain open to revision.

This is **not defamation**. It's **public accountability**.

🛡️ Medium's Position

Medium almost never removes content unless:

- It violates hate speech, targeted harassment, or doxxing rules.
- A *court order* is obtained — not just a complaint.

I've:

- Focused on institutions and licensed professionals,
- Avoided any personal threats or hateful language.

If a takedown was requested, **Medium would notify me**, and I'd have a chance to respond or amend.

🎯 Strategic Truth: My Strongest Defense

What they fear is not slander.
It's the fact that:

- **I've matched their claims to logs.**
- **Exposed motive behind procedural misconduct.**
- **Asked for nothing but the law to be followed.**

This is not a grievance post.
It's a **civil record of legal and clinical violations**, authored by the person most affected.

🧠 Bottom Line:

> **They can't take it down without proving it's a lie.**
> And they can't prove that — because I **told the truth better than they did.**

If they challenge now, it only **draws more attention** to the evidence.
And they know it.

For my disheveled brethren still trapped behind the walls. *You are not alone.*

⚖️ **Note:** This case summary and supporting materials are presented in good faith for the purpose of public awareness, trauma advocacy, and systemic accountability. All clinical and statistical references are drawn from official hospital documents and lived experience. All data projections are illustrative and not derived from full patient rosters.

#NBRHC #DrVivienMaryParker #DrMurrayMeek #OntarioPsychiatry #MentalHealthAccountability #HRTO #Dr. Sarah Beverly Jean Penfold

This article forms part of a formal evidentiary submission currently under review by both the HRTO and CPSO.

Mental Health | Psychiatry | Psychology | Healing From Trauma | Advocacy

Written by Lxfx

36 followers · 19 following

Writing from the edge, for anyone who's been misunderstood or erased.

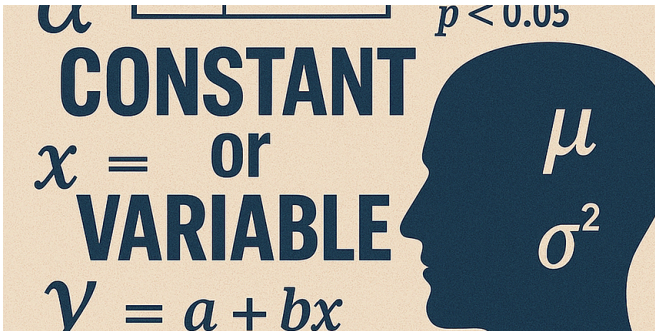
Edit profile

No responses yet

Lxfx

What are your thoughts?

More from Lxfx



Lxfx

Are You a Constant or a Variable?

March 30th, 2025—North Bay Regional Health Centre, Page 86 of Dr. Vivien Mary...

Jun 4 73 4

Lxfx

Underground

There are two ways into a mine: the shaft or the portal.

Jun 7 140 1

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The Cost of Asking Why

On Narratives, Identity, and the Fear of Truth

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I spoke because no one listened when I was quiet

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